Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: TOMBALL REGIONAL HOSPITAL PO BOX 889 TOMBALL TX 77377-0889	MFDR Tracking #:	M4-06-3785-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: American Home Assurance Co. Box #: 19	Date of Injury:	
	Employer Name	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "The Department of Workers' Compensation, then the Commission, contracted with Ingenix, Inc., in 2002 to develop MARs for a hospital outpatient fee guideline. Ingenix recommended to the Commission that a market reimbursement of 140% of Medicare's Outpatient Prospective Payment System (HOPPS) would meet the statutory requirements of Section 413.011(d).

The 2005 HOPPS median payment for CPT code 29881 is $1674.44 multiplied by 140% equals $2,344.22. Hartfor [sic] has paid $1,118.00. Please reprocess this claim and issue an additional payment to Tomball Regional Hospital in the amount of $1,226.22."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $1,226.22
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "It is the Respondents position that the Requestor was paid more than a fair and reasonable amount as determined in accordance with the criteria for payment under the *ACT*. Specifically, the amount paid by the Respondent was more than that which would be allowed under Medicare. Respondent has paid Requestor $1118.00 which is the same amount that a full service hospital would be paid for its facility charges associated with a spinal surgery and a one-day inpatient hospitalization."… "As the Requestor, the health care provider has the **burden to proof** [sic] that the fees paid were not fair and reasonable."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
10/7/2005	W10, W4	Outpatient Surgery	$1,226.22	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code W10 – "Reduced to fair and reasonable."; and W4 – "No addl reimbursement allowed after review of appeal/reconsideration. Reimbursement for your no additional monies are being paid at this time. Bill has been paid according to state fee guidelines or rules and regulations." [sic]
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division Rule at 28 TAC §134.1, 27 TexReg 4047 (May 10, 2002) which requires that "reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011"…
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division Rule at 28 TAC §133.307(j)(1)(F), effective January 1, 2003 applicable to requests for medical fee dispute resolution filed on or after January 1, 2003, 27 TexReg 12282, requires that the carrier's response to the request shall include "documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement"… The filing date of this request was February 1, 2006. The respondent has provided documentation generally to support that the carrier's methodology meets the criteria of §413.011(d) in that the method used to calculate the rate of pay is comparable to the facility reimbursement for inpatient surgery under the Division's former *Acute Care Inpatient Hospital Fee Guideline*. In support of this the respondent states: "Respondent has paid Requestor $1118.00 which is the same amount that a full service hospital would be paid for its facility charges associated with a spinal surgery and a one-day inpatient hospitalization." While the Division's former inpatient hospital fee guideline at 28 TAC §134.401, 22 TexReg 6264 (July 4, 1997) is not applicable to outpatient or ambulatory surgical care services, that former guideline specified a *per diem* reimbursement of $1,118.00 for a surgical admission plus additional reimbursement amounts as specified in subsection (c)(4). The Division has noted in another fee guideline adoption preamble that: "The general concept in the reimbursement hierarchy is that inpatient hospital services are reimbursed more than hospital outpatient services, which are reimbursed more than ASCs [Ambulatory Surgical Centers], for the same or similar services." 29 TexReg 4191, 4199 (April 30, 2004). The reimbursement methodology employed by the carrier produces a similar reimbursement amount to the Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 TAC §134.401. Review of the documentation submitted by the respondent finds that the respondent has discussed, demonstrated and justified that the amount paid is a fair and reasonable reimbursement.
5. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines)" The request for medical fee dispute resolution was received by the Division on February 1, 2006. The requestor's position statement asserts that "The Department of Workers' Compensation, then the Commission, contracted with Ingenix, Inc., in 2002 to develop MARs for a hospital outpatient fee guideline. Ingenix recommended to the Commission that market reimbursement of 140% if Medicare's Outpatient Prospective Payment System (HOPPS) would meet the statutory requirements of Section 413.011(d)." Review of the documentation submitted by the requestor finds that the requestor did not provide documentation to support the requested reimbursement. The requestor did not submit copies or evidence of the Ingenix recommendation to the Commission. And, although the requestor alleges generally that the requested reimbursement would meet the statutory requirements of §413.011(d), the requestor does not further discuss or explain how the proposed reimbursement meets any of the specific criteria set forth in §413.011(d). The requestor further states that "The 2005 HOPPS median payment for CPT code 29881 is $1674.44"; however, review of the documentation finds that the requestor has not provided any evidence (such as redacted EOBs or copies of Medicare fee schedules) to support the amount that the requestor asserts Medicare would pay for the services in dispute. Thorough review of the documentation submitted by the requestor finds that the requestor has not supported, demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional reimbursement cannot be recommended.
6. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.